Integrative Health Providers, LLC

8535 Refugee Road, Pickerington Ohio 43147
Main: 740.205.2007 Fax: 877.384.2597

Please provide the following demographic information:
First Name:_____
Last Name:_____
Patient Date of Birth:_____
Email Address:_____

Do we have permission to call and leave a message on your phone if you cannot be reached? YES or NO

Do we have permission to text you from our office line to help provide a more timely response to your needs? YES or NO

Please remember, we do not sell/share your information to anyone and we uphold all of the standards outlined for privacy for protected health information by HIPAA (the Health Insurance Portability and Accountability Act).

Below are the following office prices for services rendered by *Primary Care Providers Elizabeth Baljak, NP & Joseph Bui, NP*

- No Show Fee (No call no show OR calling & cancelling within 24 hours of appointment time): **$40**
- Self Pay Visit (First Visit Establish Care): **$150**
- Self Pay Follow-Up Visits: **$75**
- Form Fee: **$40**
- UDS: **$25**
- Refill fee: **$35**
- Sick Visit: **$40**

As a new policy as of 1/1/2025, we do ask that in addition to consenting to the financial guidelines of Integrative Health Providers, we ask that you provide a

VALID credit/debit/HSA card on file for copays or other fees that might occur. Below please provide a card number, the expiration date and the CVV Code (on the back of the card):

Credit Card Number:_____
Credit Card Expiration Date:_____
Credit Card CCV (number on back of card):_____
For invoicing and receipts, an email address is required (if different from above, if not insert N/A):_____

- If this card number changes, please contact the office as soon as possible to provide a new one to the billing department. Integrative Health Providers will also make 3 phone call attempts to reach out if there are any issues with your billing account.

- If an appointment is missed, please note that a payment arrangement will need to be made with the billing office of IHP or paid in full before the next appointment can be scheduled.

- By signing below, I hereby acknowledge that I have completely read and fully understand the Integrative Health Providers Financial Responsibility and Self Pay Guidelines. If you have any further questions, please don't hesitate to reach out to the billing office of IHP.

Signature of Agreement:

- X_____
- Printed Name: _____
- Date: _____